MEDICARE PART D 2017- INTAKE FORM

CLIENTS: Please complete the following information in preparation for your meeting with the attorney.

Print Name:_____ **Date of Birth:** _____ **Preferred Language** _____

CLIENT SIGNATURE: _____ **Social Security Number:** _____-_____-_____

Address:_____
(Street) (City, State: DC, MD, VA or other) (County) (Zip Code)

Phone: (home)_____**(cell)**_____

Email: _____ **Are you legally married?** ☐ **yes** ☐ **no**

Do you identify as ☐ **Gay/Lesbian** ☐ **Straight** ☐ **Bisexual** ☐ _____

Do you identify as ☐ **Male** ☐ **Female** ☐ **GenderQueer/Non-binary** ☐ _____

What is your total monthly income (include spouse): $_____
Source: ☐ **SSI** ☐ **SSDI** ☐ **SS Retirement** ☐ **Employment** ☐ **Other** _____
List any assets (i.e., cash, checking, savings, stocks, etc.) and their value? $_____

What is your Medicare number: _____-_____-_____-____

Part A ☐ **yes** ☐ **no** **If yes, effective date:** _____
Part B ☐ **yes** ☐ **no** **If yes, effective date:** _____
Part D ☐ **yes** ☐ **no** **If yes, plan name:** _____
Medicare Advantage (HMO-Medicare) ☐ **yes** ☐ **no** **If yes, what plan?** _____

Do you also have private health insurance? ☐ **yes** ☐ **no** **If yes, what plan?** _____

LIST YOUR PHARMACY AND PRESCRIPTION DRUGS

What pharmacy (and location) do you prefer to use? _____

(What drugs are you taking or anticipate taking – list below OR attach a list from your pharmacy or doctor)

Prescription Drug Name	Dosage	Number of Pills You Take Per Day

WEBSITE DRUG LIST ID: _____ **PASSWORD DATE:** _____

***Attach a copy of your Medicare (red, white, and blue card), Medicaid card (if applicable) and/or QMB card (if applicable).**

Program Enrollment Information [for WWH Staff purposes ONLY]

Medicaid? ☐ **yes** ☐ **no** ☐ **n/a** **Recert Date:** _____ **Client has met with PBIN?** ☐ **yes** ☐ **no** ☐ **n/a**
QMB? ☐ **yes** ☐ **no** ☐ **n/a** **Recert Date:** _____ **if yes, when?** _____
LIS? ☐ **yes** ☐ **no** ☐ **n/a**
ADAP? ☐ **yes** ☐ **no** ☐ **n/a** **Recert Date:** _____ **PBIN sign off** _____

For WWH Internal Purposes ONLY

Intake Received: _____ **Anticipated Clinic Date or phone:** _____ **Analysis Completed and closed** _____ **Legal Server #:** _____ **Admin Sign-off** ☐

ATTORNEY COMPLETION ONLY: Please complete the following information completely.

Volunteer Name: _____ Phone: _____
Law Firm: _____ E-mail: _____
Today's Date: _____

Action Taken by Volunteer Attorney or WWH Staff:

1. How did you assist the client? ☐ In-person ☐Telephone
2. On the medicare.gov website, I have conducted a ☐ personalized or a ☐ generalized plan search.
3. Create a medications list, or confirm the existing drug list with the client.
   The password should always be changed to the client's date of birth.
4. ☐ I printed the plan details for the client's current/default plan for 2018; or
   ☐ The client's 2017 plan has been discontinued for 2018 (and no default plan was listed).
5. Complete the plan analysis. Be sure to consider the monthly premium ($0 for LIS, preferably), annual drug cost, drug restrictions, and pharmacy network for the client.

Summarize your findings and analysis

2018 Plan Recommendation: _____
Current/default plan: Monthly Premium Amount $_____ New plan: Monthly Premium Amount $_____
Current/default plan: Annual Retail Drug Cost 2018 $_____New plan: Annual Retail Drug Cost 2018 $_____

☐ I have attached the plan details for the recommended plan for 2018, including any drug restriction details.

6. Did you need to call the plan? ☐ Yes ☐ No
   If yes, why?_____
   Number called _____Name of service representative _____
7. Review your plan recommendation with a supervisor. **Supervisor Initials**_____
8. Did you enroll the beneficiary in a plan? ☐ Yes ☐ No Enrollment Date: _____
   If yes, was it the recommended plan? ☐ Yes ☐ No, why? _____
   Did the client change plans? If so, why? _____
   ☐ I printed a copy of the enrollment grid containing the client's personal information.
   ☐ I printed a copy of the "Enrollment Successful" confirmation page.
   If no:
   ☐ I counseled the client to stay in the current/default plan for 2018.
   ☐ There is follow-up required for this plan analysis, as follows:

   _____

   _____

   _____
9. Please provide your client a take-away form and copies of the plan details/enrollment.
   ☐ I gave the client a copy of the take-away form, plan details, and enrollment confirmation.
   ☐ I attached a copy of the take-away form, plan details, and enrollment confirmation to this intake for WWH.

Follow-Up Action Provided by:_____ Date:_____
Any other action taken? ☐ Yes ☐ No If yes, please describe below.